Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N003001	A. BUILDING _____ B. WING _____	09/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATCHISON SENIOR VILLAGE	1419 N 6TH ST ATCHISON, KS 66002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and complaint investigation #KS59801.	S 000		
S1174 SS=E	26-40-303 (2)(a)(i)(ii)(iii) P E - Door monitoring system (2) Door monitoring system. The nursing facility shall have an electrical monitoring system on each door that exits the nursing facility and is available to residents. The monitoring system shall alert staff when the door has been opened by a resident who should not leave the nursing facility unless accompanied by staff or other responsible person. (A) Each door to the following areas that is available to residents shall be electronically monitored: (i) The exterior of the nursing facility, including enclosed outdoor areas; (ii) interior doors of the nursing facility that open into another type of adult care home if the exit doors from that adult care home are not monitored; and (iii) any area of the building that is not licensed as an adult care home. This REQUIREMENT is not met as evidenced by: KAR 26-40-303 (2) The facility had a census of 46 residents. The sample included 23 residents. The facility identified 9 independently mobile and cognitively impaired residents. Based upon observation,	S1174		

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S1174	Continued From page 1	S1174		

record review and interviews the facility failed to ensure all exit doors were electronically monitored to alert staff when 1 (#51) resident opened the door and left the facility.

Findings included:

- Review of resident #51 ' s September 2012 Physician ' s Order Sheet identified the resident had diagnoses that included: history of falls, abnormality of gait, altered mental status and paralysis agitans (Parkinson ' disease).

The resident ' s admission Minimum Data Set (MDS) 3.0 dated 8/12/12 identified the resident scored 9 (moderately impaired cognition) on the Brief Interview for Mental Status and had inattentive and disorganized thinking.

A nurse ' s note dated 8/22/12 timed 2:45 P.M. documented that at 1:20 P.M. staff was informed a resident fell outside, staff exited the facility and observed the resident sat in the grass, had taken his/her socks off, and an individual was with the resident. The licensed nurse asked the individual if he/she saw the resident fall and the individual stated no but saw resident #51 crawled down the hill.

A nurse ' s note dated 8/22/12 timed 3:30 P.M. documented a neighbor entered the facility and alerted the facility a resident was outside. The note included another neighbor stayed with the resident and reported to facility staff the resident crawled down the hill. The note included at approximately 1:20 P.M. the wireless call system received a page the back door alarmed.

On 9/13/12 at approximately 9:40 A.M. observation revealed a keypad located next to the

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S1174	Continued From page 2 exit door identified by the facility as the back door. Further observation revealed if a code was not entered into the keypad, the back exit door alarmed and sent a page to the wireless call light system. During interview with maintenance staff XX1 on 9/13/12 at approximately 8:40 A.M. staff stated the magnetic lock on the back door was faulty and did not send an audible sound when the resident opened the back door (door located between the 200 and 300 hall breezeway). Maintenance staff XX1 stated the wireless call system received the page someone had opened the door. Maintenance staff XX1 stated the door alarms and the wireless call system were not wired to the same system. Maintenance staff XX1 stated he/she checked the exterior door alarms on a monthly basis and he/she last checked the exterior door alarms on 8/9/12 and the door alarm sounded on that date. The facility ' s security doors policy and procedure (undated) included all exterior doors, within the living areas of the facility, were Mag-locked and alarmed. Door alarms were armed at all times. The facility failed to ensure all exit doors were operable to alert staff that a resident left the facility.	S1174		